Causes of acute abdominal pain in children

Common causes

• Appenticitis • Non-specific abdominal pain

Uncommon causes

Meckel's diverticulitis, mesenteric adenitis, Crohn's disease, sickle cell crisis, gall stones, pancreatitis, tonsillitis, otitis media, acute hapatitis, acute porphyria, intestinal bands, malrotation, ureteric calculi, urinary tract infection, pneumonia, peptic ulcer disease, psychogenic, Henoch-Schönlein purpura, intussusception, yersinia infection, obstructed inguinal hernia, torsion of testicle, omental infarction, renal vein thrombosis, acute hydronephrosis, primary peritonitis, salpingitis, ovarian cyst, ectopic tubal pregnancy, pyelonephritis, trauma, infective gastroenteritis, food poisoning, child abuse, attention seeking behaviour, intestinal volvulus, choledochal cyst, cholangitis, foreign body, adhesions and small bowel obstruction, pica, ketoacidosis

Renal and ureteric calculi, though rare, are a potent cause of acute abdominal pain, with most being associated with chronic urinary infection. Children with neurogenic bladders (for instance, those with spina bifida) are prone to develop this problem.

Upper abdominal pain

Acute upper abdominal pain is much less common in children than in adults, but if it occurs in older children, and particularly if it is recurrent, thought should be given to gall stones (especially in children with chronic haemolysis, such as sickle cell anaemia), peptic ulcers, and pancreatitis (often associated with a choledochal cyst).

1 Jones PF. Active observation in management of acute abdominal pain in childhood. *BMJ* 1976;ii:551-3.

Professor Lewis Spitz, Institute of Child Health, London, provided the pictures of faecalith, gangrenous appendicitis, and Crohn's disease.

The ABC of Paediatric Surgery is edited by Mark Davenport, consultant paediatric surgeon, department of paediatric surgery, King's College Hospital, London.

Children on hunger strike: child abuse or legitimate protest?

A Mok, E A S Nelson

The issue of children on hunger strike (voluntary total fasting) has not been reported before. The World Medical Association Declaration of Tokyo 1975 and the Declaration of Malta 1991 (revised 1992) provide clinicians with guidelines for the management of adult patients on hunger strike[1,2] but do not mention children. We report the management of 14 Vietnamese children, aged 1 to 12 years, who took part in a hunger strike at a refugee detention centre in Hong Kong.

The influx of Vietnamese boat people to Hong Kong and other South East Asian countries began in the 1970s. Initially all were deemed to be political refugees who would be resettled in a third country. This policy was then revised and over 20 000 refugees were reclassified as "economic migrants" for repatriation to Vietnam. Some returned under a voluntary repatriation programme, but most resisted. Earlier attempts at forced repatriation were opposed by the United States Administration. A resumption of forced repatriation, together with a possible reversal of United States policy, was reported in the local media in September 1994.[3] This resulted in the north section of the High Island Detention Centre (population 1500) embarking on a hunger strike. Everyone in this section, including children, fasted or were fasted, for up to five days. Only water was taken orally. Breast feeding was allowed, although mothers were expected to fast.

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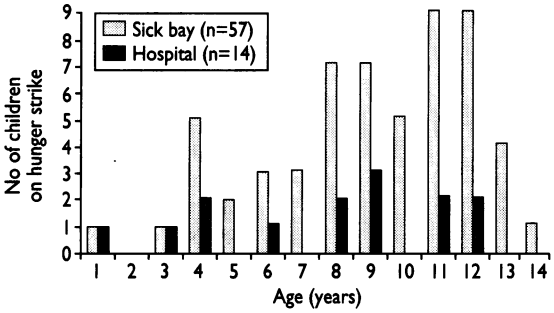
The hunger strike

Sixty seven hunger strikers made 93 attendances to the camp sick bay during this period. Fifty seven of the attendees were children under the age of 15 years (fig 1). Attendees were assessed, given treatment for minor complaints, and offered food and oral rehydration fluid. Parents were advised of their responsibility to feed their children and of the clinical consequences of withholding food.

Fourteen children were transferred from the camp sick bay to the Prince of Wales Hospital. No parents objected. The youngest "hunger striker" was less than 2 years old (fig 1). All children had some degree of ketonuria and two were hypoglycaemic. Normal ward diet was offered and no child refused food.



Age distribution of children on hunger strike

In the absence of guidelines or previous experience, we considered that total fasting of the children was a form of child abuse and we did not discharge the children until we were satisfied that they would be fed normally. Fortunately after five days, before major logistical problems developed, the hunger strike stopped.

Parents were interviewed when their children were discharged. On direct questioning no parents admitted secretly feeding their children and some indicated that there had been coercion. The reasons they gave as to why they let their child fast included regretting it but thinking it was right; that it had been their child's own decision to fast; or that they had been forced by the leaders to fast their child. Some older children claimed that they had begun the hunger strike voluntarily because their parents and everyone else were fasting, and they believed that such action might have prevented them from being sent back to Vietnam. Parents were informed that we considered this an unacceptable form of political protest, and we emphasised the potential adverse effects on their children's health.

Discussion

A hunger striker is defined as a "mentally competent person who has indicated that he has decided to refuse

to take food and/or fluids for a significant interval."[2] The Declaration of Malta acknowledges the doctor's dilemma in which s/he must respect "the sanctity of life" and "the autonomy of the hunger striker." These dilemmas and the doctor's role in managing adults on hunger strike have been addressed.[4] We were, however, faced with three new dilemmas: at what age can a child be considered mentally competent to form an unimpaired and rational judgment concerning the consequences of such voluntary refusal of nourishment? Secondly, how do you manage children below this age who are forced to fast? And thirdly, how do you implement medical intervention without escalating political tension?

Some children as young as 8 years stated that they had acted of their own free will. Children under 16 years of age do have some rights to self determination.[5,6] The United Kingdom Children Act of 1989 states the rights of children to make an informed decision in medical intervention that concerns them. They can refuse to submit to any examination, assessment, or treatment. Some recent British court rulings, however, have led to debates about these rights and the competence of the children to make decisions—especially if they reject professional advice.[7,8] There are thus no clear guidelines for judging at what age a child becomes mentally competent to take part in a hunger strike. We can conclude, however, that a very young child cannot be considered a hunger striker. These younger children were forced to fast because their parents stopped feeding them. It can be argued that if a parent believes that their protest is worth dying for, they are justified in starving their children in the process. But a child has the right to protection from parental exploitation resulting from an attempt to secure political gain.[5]

Prolonged total fasting of a child, which poses a considerable health risk, can be considered a form of child abuse for which a case conference may be required to determine appropriate management. Ideally the clinician should proceed carefully, with legal advice if appropriate, to decide the best management of each individual child, taking into consideration individual differences in age and level of understanding, and acknowledging the controversies attendant on the child's right to self determination, external influences and possible coercion, and the lack of any clear guidelines. Such statements are easier to make than to implement. Had we attempted forced removal of children from the detention centre, we would have experienced considerable logistical problems and probably have escalated the political tension.

What, therefore, should be done under such circumstances? Undoubtedly clear guidelines, appropriate to the child's developmental age and endorsed by the international community, would be an important starting point. This would allow would-be hunger strikers, law enforcement officers, and medical staff to know clearly what is and is not acceptable. Should protesters flout such guidelines, then diplomacy, counselling, and hope of an early resolution would probably be the next step. At a local level, inconsistent policies and continuing delays in achieving political solutions to the Hong Kong Vietnamese refugee problem increase the likelihood of further hunger strikes or other actions.

We thank Dr WJR Taylor of the British Red Cross for supplying information relating to treatment provided at the camp sick bay.

1 Declaration of Tokyo. Guidelines for medical doctors concerning torture and other cruel, inhuman or degrading treatment or punishment in relation to detention and imprisonment. *World Med J* 1975;22:87.
2 World Medical Assembly Declaration of Malta on Hunger Strikers. Adopted by the 43rd World Medical Assembly Malta, November 1991 and editorially revised at the 44th World Medical Assembly Marbella, Spain, September 1992.
3 US to push for forced return of Vietnamese. *South China Morning Post* 1994 September 14.
4 Kalk WJ, Veriava Y. Hospital management of voluntary total fast among political prisoners. *Lancet* 1991;337:660-2.
5 The Convention on the Rights of the Child. Adopted by the General Assembly of the United Nations 20 November 1989.
6 *The Children Act 1989*. London: HMSO, 1989.
7 Shield JPH, Baum JD. Children's consent to treatment. *BMJ* 1994;308:1182-3.
8 Devereux JA, Jones DPH, Dickenson DL. Can children withhold consent to treatment? *BMJ* 1993;306:1459-61.

In England starving your child would amount to "criminal neglect"

John Murphy

From a legal perspective, Mok and Nelson's article touches on three interesting questions all of which, regrettably, the authors fail fully to address. First, there is the issue of whether children can be compelled to eat against either their own wishes or those of their parents. Secondly, the authors address on the question of whether parents who starve their children are engaging in a form of "child abuse." Finally, their article provokes, but fails to engage in, discussion of a key question concerning the impact of international conventions on domestic laws.

In relation to the first matter, the authors are apt to mislead when they claim that the 1989 Children Act states the rights of children to make an informed decision in medical intervention that concerns them. The 1989 act does no more than confer a right *to have a say*[1] in such matters (except where a *medical assessment* of a child in local authority interim care is proposed).[2] It is equally difficult to appreciate why they should cite both this act and a number of English decisions in relation to the problem concerning Vietnamese children in Hong Kong about whom their article was written. It is equally uncertain that there was a problem with respect to the provision of food to these child hunger strikers: all we are told is that they were being treated at camp sick bay. If their parents took them there then surely there was implied consent to the children being fed and their hunger strike being treated as at an and. On the other hand, perhaps the authors were trying to assess what the position would be in this country. But if they were, it would have been helpful if they had said so and explained why they thought it was an issue of any practical importance here. Much more likely—and this is borne out by the English case law[3]—is the prospect of children not so much hunger striking as having anorexia nervosa.

As to the second legal issue raised by their article, the authors ask: is starving one's children "child abuse for which a case conference may be required to determine appropriate management?" Again, they fail to make clear whether they are concerned with the appropriate clinical response in this country or in Hong Kong, where the problem arose. If they are discussing Hong Kong, can we assume that the appropriate English clinical response is also the appropriate one in Hong Kong?[4] (If not, then why mention it?) Do clinicians there deal with problems in the same way as their

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